



Medical Operations in Counterinsurgency Warfare: Desired Effects and Unintended Consequences

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PHOTO: U.S. Navy Hospitalman 3 Steven Goff attends to an Afghan man in need of medical attention in Khasakabad Nawa, Afghanistan, on 7 October 2009. The Afghan had a severe insect bite on his leg. Photo by SGT Freddy G. Cantu, U.S. Marine Corps

MEDICAL OPERATIONS ARE common in Iraq and Afghanistan, and the press reports about them frequently. Are they medically effective or are they harmful? Do they further the counterinsurgency fight, or hinder it? Other than press reports, not much published information about medical operations exists for reference when commanders and their staffs plan or execute such missions.

Brigade combat team (BCT) and battalion commanders conducting counterinsurgency warfare often use their combat health support (CHS) personnel and equipment for non-CHS purposes, namely to provide medical care to the civilians within their areas of responsibility. These operations have various doctrinal and non-doctrinal names—including medical civic action programs (MEDCAPS), combined medical engagements, or cooperative medical engagements—but they typically involve U.S. medical personnel at the battalion level, with or without the participation of indigenous medical personnel, providing care to civilians for a short period of time. For the purpose of clarity, we shall collectively refer to these missions as *medical operations*.

Commanders have one or more motives for conducting medical operations. These may include desires to be beneficent, to influence local civilians so that the commander can gain an advantage over the insurgents, to gather intelligence, or to generate positive content for information operations.

If the commander's motive is humanitarian, he must be aware of the capabilities and limitations of his medical assets as they relate to the indigenous population, and he must be alert to the medical harm that may result from the attempt to provide medical care.

When gaining influence is the commander's motive, medical care essentially serves as a commodity, which the commander hopes to trade in return for good will or cooperation.

When gathering intelligence is the commander's objective, medical care draws a permissive crowd from which to elicit tactically useful information.

When using the medical operation as an information operation, the commander must ensure that appropriate media are present to carry the message to targeted audiences, rather than media that simply project the message back to coalition forces.

This article examines medical operations through the lens of counterinsurgency principles and seeks to determine if BCT and battalion medical assets can be effectively used for humanitarian, influence, intelligence-gathering, or information operation missions.¹ We will examine the unintentional medical and tactical consequences of these missions—which can undermine higher-echelon commanders' operational and strategic counterinsurgency objectives—and suggest the most effective ways for commanders to employ their medical assets to further the counterinsurgency war.

Capabilities and Limitations of Medical Assets

Brigade combat team and battalion-level CHS assets are tailored to provide a specific range of medical services (primary care and trauma stabilization) to a specific population (healthy young Soldiers). Primary care within the BCT includes preventive medicine, the management of acute minor illnesses and injuries (e.g., colds, urinary tract infections, skin infections, sprains, lacerations, and simple fractures), and the management of chronic minor conditions (e.g. high blood pressure, lower back pain, and allergies). Family physicians, internal medicine physicians, pediatricians, physician assistants, and family nurse practitioners usually provide these services.

Successful treatment of chronic (long-term) illnesses requires ongoing care, and preferably continuity of care, which is accomplished when the same physician treats a patient over a long time, or when different physicians treating a patient have access to his medical record for reference and for generating new entries. This is important. Physicians *cannot* effectively treat a patient's chronic illnesses (such as diabetes, hypertension, or emphysema) with a one-time encounter when no medical record exists for reference, and the treatment generates no medical record for future reference.

A deployed BCT may have one or more “professional filler system” physicians attached. These physicians may not be primary care physicians, but medical specialists or subspecialists, such as cardiologists, dermatologists, or endocrinologists. However, despite their specialized skills and knowledge, without the support of trained assistants, sophisticated laboratory facilities, and specialized equipment, they are not able to function much beyond the role of a primary care physician. Their potential is constrained by their environment. For example, a trauma surgeon inside an evacuation vehicle is no more useful to an injured Soldier than is a well-trained and equipped combat medic. The trauma surgeon only performs to his potential when he is in an operating suite with assistants, anesthesia support, blood products, and an intensive-care recovery room, just as an infantry BCT commander without his staff, Soldiers, or his command and control systems is, notwithstanding his education and experience, no more than a rifleman.

Medical Operations in Counterinsurgency

As with any military mission, medical operations at the battalion or BCT level should nest within the intent of the division and corps, so that they support counterinsurgency principles and imperatives.² Most would agree that a foreign military cannot succeed in counterinsurgency by simply doing kind things for the population. A common term for medical operations is “random acts of kindness,” implying that they create no sustainable gain, are not laterally synchronized, and are not nested with strategic plans.

To succeed, foreign military and host nation forces must cause the population to respect and rely upon the native government. It is necessary for the people to either fear the government more than they fear the insurgents, or to trust the government to protect them from the insurgents. Our use of the word “fear” does not mean that we endorse brutality. We are simply saying that the population must fear the legitimate lethal and non-lethal martial and civil consequences of passively or actively supporting insurgents. U.S. forces may engage in efforts designed to make Iraqis or Afghans like Americans, rather than to make them stakeholders in their own government institutions. After one



U.S. Army photo by SSGT Tyrone Clakely

U.S. Army MAJ Tom Schumacher, left, gives medical aid to an NCO at Joint Security Station War Eagle, in Baghdad, Iraq, 23 August 2009.

BCT's assessment of an Iraqi hospital in 2008, during which the hospital director requested 30,000 liters of fuel to run his generators (despite admitting that his fuel tanks were pilfered nightly), the BCT surgeon discussed the request with another medical officer. "Americans have been giving him fuel for years. We must stop, or he will never force his own system to work," the surgeon said. "But if I give him fuel," said the other officer, "*then I will be his hero.*" Of course, the objective is not to be the hospital director's hero, but make the hospital director more reliant on his own government for diesel deliveries or electrical power.

This problem of fostering an unhealthy reliance on U.S. resources is not unique to medical operations. For example, a 2008 article in the *Washington Post* stated that—"In a Senate hearing this spring, [U.S. Senator] Levin recalled a recent trip to a base near Diyala . . . [A] senior U.S. military officer told him of a successful garbage-collection program, paid for with [U.S.] money, and the thanks he received from an Iraqi official, who added, 'As

long as you are willing to pay for the cleanup, why should we?'"³

In general, we should conduct medical operations only if they are likely to cause the local population to become more reliant on and confident in their indigenous medical institutions, supporting the strategic counterinsurgency goal of legitimizing the native government.

The Humanitarian Medical Operation: Unnecessary, Futile, or Both?

Khidr, Iraq—An old woman wailed crazily as a man whose legs were blown off months ago was wheeled past the concertina wire. Hundreds of people . . . lined up amid mud and rubble for a medical clinic held by American troops in this rural village northwest of Iskandariyah . . . "I'm not going to be able to treat him," [Dermatologist Lt. Col. Tim] Monahan said quietly, standing in the doorway of a dimly lit classroom . . . [H]is

amputations appeared to be healing well. The best thing, Monahan told him, was to wash with soap and hot water, but the man wanted medicine . . . After some negotiations, he left for the rubble with four tubes of ointment and a bottle of betadine [antiseptic].⁴

This scenario is an easy trap to fall into. Appalled by the condition of local medical facilities, an American commander believes that the people have no access to healthcare or are afraid to cross sectarian boundaries to clinics or hospitals. He talks to a local sheikh or tribal leader and arranges to conduct a medical operation. Unfortunately, neither of them recognizes that transient battalion aid station medical practice is worse than consistent indigenous medical practice, when it comes to the diagnosis and treatment of chronic diseases in the local population. Major Greg Brewer, chief medical planner for Multinational Division-Baghdad, put it this way: “To me it makes more sense for us to be aiding and assisting the [Ministry of Health], rather than to be doing their job for them [with mediocrity] . . .”⁵

Consider the validity of some assumptions we may make when considering a medical operation. One is that the indigenous people have little or no access to healthcare. This may be true in some sparsely populated areas, but this is of little relevance to the medical assets within a BCT (for reasons that we will discuss later), and may be a false assumption. One medical officer participated in an operation in a rural area outside of Taji, Iraq, where people who reportedly had no access to medical care appeared with the recent results of sophisticated laboratory tests, ultrasound reports, tissue pathology reports, and computerized axial tomography (CAT) scan images. Colleagues have described similar experiences in rural areas of the Diyala Province. We should recognize that although we may not be familiar with the capabilities or locations of all the indigenous physicians or medical facilities in the area, the locals are. We are prone to project our unawareness onto the local population and to allow them to capitalize on our ignorance or sympathies to obtain services, which they—incorrectly—perceive as valuable.



U.S. Marine Corps photo by SSCT William Greeson

Medical treatment facility in Helmand Province, Afghanistan, 4 July 2009. The room has been used to treat Marines, Afghan National Army soldiers, and civilians.

Another assumption, at least in Iraq, is that people are too fearful to cross boundaries to obtain medical care. However, is this fear rational? According to the *Los Angeles Times*, 2,155 Iraqis died violently in Baghdad in May 2006, at the height of the insurgency. (This number includes insurgents killed by coalition forces.)⁶ If the population of Baghdad was 5.5 million at the time, then the annual violent death rate was only 0.47 percent (470 per 100,000 per year). Although ten times higher than Detroit's annual murder rate (47 per 100,000 per year), does a daily death-risk of 0.0013 percent (1.3 per 100,000 per day) really justify avoiding the market or a hospital?⁷ U.S. forces should not reinforce enemy propaganda by accommodating the population's fears. Rather, they should work to dispel those fears and to encourage normalcy as much as possible.

Before a battalion or BCT commander directs his medical assets to provide care to a civilian population, he and his medical officers must determine what common diseases exist in the community and whether CHS personnel and equipment can feasibly address those problems.

On any given day, less than two to three percent of people have an acute (brief and/or sudden) minor illness or injury that is amenable to diagnosis and treatment by a medical platoon or company. Many acute conditions resolve spontaneously and do not require treatment. The vast majority of people are either relatively well or have chronic illnesses, so the deployment of BCT or battalion medical assets to attempt the diagnosis and treatment of acute medical problems is largely unnecessary.

In the United States, the most common chronic medical conditions are diabetes, hypertension, arthritis, emphysema (from smoking), asthma, heart disease, cancers, and mental illnesses.⁸ These same chronic diseases are common among Iraqis. In October and November of 2007, the United Nations Refugee Agency surveyed over 700 Iraqi refugees living in Syria, and found that 17 percent of respondents had chronic diseases, the most common being hypertension, diabetes, heart problems, lung problems (emphysema and asthma), and arthritis.⁹

Chronic illnesses are often preventable, largely self-inflicted by lifestyle choices, generally incurable, and progressively worsen with time. Dietary measures, exercise, tobacco cessation, and consistent life-long medication use often slow disease

progression. Since chronic illnesses require ongoing care, medical platoons or companies cannot effectively treat them in the local population. Consider the medical futility of this Baghdad operation:

Consultations at the clinics are brief, often extremely so. Vital signs are rarely checked. Medics dispense a range of over-the-counter medicines and antibiotics . . . with no possibility of follow-up visits to gauge patients' progress. Dr. (Captain) David Escobedo, a family practitioner from the 1st Infantry Division of Schweinfurt, Germany, said he questions the medical value of the four-hour operations . . . "These can't possibly make a long-term impact, since these are a one-time deal," he said during a . . . September clinic in the Shi'ite neighborhood of Ur. "That's the biggest frustration. Not being able to see these people again and follow up." . . . Another frustration, he said, is his inability to use laboratory tests to diagnose patients, or to provide more than basic help . . . Cases can be severe, as in the case of a tall, proud looking woman who carried in her 10-year-old son, a thin boy with severe deformities, club feet and atrophied limbs. She set him on an exam table and begged for help . . . "There's nothing that we can do for him here," Escobedo said apologetically. "We can give him some vitamins."¹⁰

Despite the futility and frustration illustrated above, the typical medical operation consists of battalion medical personnel setting up a temporary "sick-call" clinic in a school or other building, where a large number of people with mostly chronic illnesses and unrealistic expectations of cure quickly overwhelm them. Many people are not sick at all, but only curious.¹¹ Severe time constraints, lack of sufficient interpreters, and absence of basic diagnostic equipment such as laboratory tests and x-ray imaging compound these frustrations.

The reader will appreciate the futility of this healthcare model if he imagines having chest pain, a cough, or bloody urine; tries to explain his symptoms to a foreign physician (who speaks no English, but only has one shared and harried interpreter); imagines the physician performing a physical exam, correctly diagnosing the problem (without any diagnostic equipment), and then imagines him formulating an effective treatment plan—all within three minutes!

It is perhaps counterintuitive, but the most effective means to improve civilian health are nonmedical. The means are ensuring security, dispelling fear caused by insurgent propaganda, and subtly assisting local authorities with clinic or hospital infrastructure repair or development. Doing so should facilitate freedom of movement of patients, physicians, and medical supplies. Physicians who feel secure will naturally want to work at their clinics or hospitals, and if they are getting paid, will probably encourage their expatriate colleagues to return home. Truck drivers who feel safe will be more likely to arrive at hospitals with supplies and medications. People who feel secure will be more likely to travel to a local clinic. Dr. Abbas al-Sahan validates this assertion by saying, “When there’s a good security situation and good economic improvement of the country, the work will grow,” describing the increasing demand for cosmetic surgery in Iraq, and the return of physicians who had left due to fear of violence.¹² If the commander treats the underlying disease (insecurity and restricted movement), then the symptom (poor access to healthcare, or poor health) will improve naturally. These actions have a greater chance of sustainably improving the health of Iraqis or Afghans than do any number of operations in which U.S. forces provide transient, poor-quality medical services.

A typical humanitarian medical operation (although relatively easy to execute) is an exercise in futility. Senior commanders have prohibited U.S. physicians from providing any *but* emergent care (life, limb, or eyesight) to civilians, but as abundant media reports indicate, well-intentioned but misguided subordinates routinely violate the prohibitions.¹³

First, Do No Harm

We can apply the medical principle of “do no harm” in a military context—tactical, operational, or strategic. Just as physicians consider the potential harms of interventions and medications they prescribe, combat commanders consider the second- and third-order effects of their operations, including unintended negative consequences. Medical operations are a morass of well-intentioned mistakes, ranging from medical harms to strategic errors. Commanders and their medical advisors

must deliberate carefully and mitigate the likely adverse outcomes of medical operations, if they choose to execute them at all.

The likelihood of causing medical harm during these operations is high. The combination of an overwhelming number of civilians (usually in the hundreds), a small number of physicians or physician assistants (usually one or two), the short duration of the operation (usually four to six hours), the absence of minimal diagnostic equipment, and language and cultural barriers are a recipe for disaster.

Once engaged in the operation, there is tremendous pressure—to *do something*—even if it is not helpful and is potentially harmful. We dispense pain medications and antibiotics without restraint. Do we ever learn of the child for whom we unnecessarily prescribed antibiotics for a viral cough, and who suffered a serious allergic reaction because we were unaware of her penicillin allergy? Do we hear about the woman we gave acetaminophen to for hip pain, who developed liver failure because we were unaware of her chronic liver disease? What about the man who complained of rectal bleeding, left the clinic with a tube of hemorrhoid cream and a false sense of reassurance, and was later diagnosed with colon cancer, by then incurably metastasized? How about the mother who gave her feverish child too much ibuprofen because of an error in calculating the weight-based dose, causing the child’s kidneys to fail? Or the man who developed severe infectious colitis after being given an unnecessary antibiotic for a cold?

These real medical errors occur in the United States, so we can assume that they occur during medical operations. However, due to the transient nature of medical operations, U.S. and allied local physicians rarely learn of the consequences of their well-intentioned efforts. In addition to the ethical questions raised by this type of medical practice, these medical harms can provide fuel for enemy propaganda, and foster mistrust of Americans, or worse, of involved indigenous physicians.

Do Expectations Create Suffering?

Other cases were more severe. In a few heart-breaking instances, parents entered the rooms cradling crippled or blind children, their eyes pleading for a magic cure . . .

Besides offering something for the pain, there was little the medics could do for patients with chronic, severe illnesses. As trained healers, it was something they all found frustrating.¹⁴

The failure to meet unrealistic expectations is a common thread of medical operations. Iraqis or Afghans may believe that they will benefit from superior medications, skills, or knowledge; or that the Americans will cure their children of incurable diseases. Consider the amputee who left with a tube of ointment; or the desperate mother who brought in her severely deformed son, only to be given a vitamin.

Dozens of headlines in unit newspapers or *Stars and Stripes* proclaim the “success” of one medical operation or another, in which “U.S. physicians provide medical care to 400 Iraqis” (*in 3 hours*). They tout quantity but do not mention quality. Commanders should read between the lines to consider the tactical consequences of people leaving the operation disillusioned, disappointed, or angry, their expectations of miracle cures, wonder drugs, or Learjet trips to the Mayo Clinic unfulfilled. Their disappointment can foment anger and incite behavior that is more malignant.

To avoid creating disappointment and potential backlash, commanders and their medical officers should set appropriate (low) expectations in advance of medical operations, outlining what their medical personnel will and (more importantly) will *not* do. For example, a commander could tell a community leader, “My Soldiers will distribute dental floss, toothpaste, and toothbrushes; and will provide education on the prevention of tooth decay and gum disease. They cannot and will not attempt to diagnose or treat illnesses.”

Competition with the Indigenous Clinics and Hospitals: Reducing the Number of Stakeholders

Military operations must not undermine the peoples’ respect for, reliance on, or trust in their government institutions, including healthcare institutions, regardless of the institutions’ state of dysfunction. Iraqis or Afghans who depend on their government institutions are less likely to support destructive efforts against those institutions. Those who are not are more likely to be ambivalent about or supportive

of destructive efforts against those institutions.¹⁵

Medical operations establish parallel health care venues that compete with and delegitimize indigenous healthcare institutions and physicians, foster inappropriate dependence on American assets, and discourage development of local resources. What messages are we sending when we establish a temporary clinic 10 kilometers from the Abu Ghraib Hospital? “We have better medicine.” “We do things better than your doctors.” “You can’t trust your hospital to take care of you.” “It is not safe to drive to the hospital.” The Khidr medical operation (referenced above) illustrates the problem of competing with legitimate hospitals. The attendees at that medical operation were “within traveling distance of *seven* [Iraqi] hospitals.”¹⁶

What is Right versus What is Easy

Most deployed U.S. physicians will encounter several civilians with tragic medical problems and may attempt to evacuate them to U.S. military hospitals. Some herald treatment of sensational and tragic cases as evidence of the success of a medical operation or use it to justify an exception to the medical rules of engagement.¹⁷ But doing so actually thwarts the redevelopment of indigenous medical professionals and institutions. While transient U.S. combat surgical hospital care will (at least temporarily) benefit the patient in question, local physicians cannot develop their practices if we stunt their progress by diverting their patients into our evacuation system.

When confronted with these heartbreaking situations, we must choose the “hard right,” rather than the “convenient or emotional wrong.” If pressed to provide care for a seriously ill civilian, we should induce or coerce local physicians to provide the best available indigenous care and only evacuate the civilian into the military system if we expect to gain a compelling tactical advantage by doing so.

Operations Scrutiny

Brigade Combat Team and battalion medical personnel cannot effectively provide care to Iraqis or Afghans with chronic health problems, and on any given day, only a small percentage of people have acute minor illnesses or injuries requiring treatment. Attempts to provide diagnostic or curative



Afghan girls wait for medical treatment in the village of Zakuzi in the Zabol province of Afghanistan, 18 November 2009. U.S. Army medical personnel and Afghan physicians provided villagers assorted medical services during a civil affairs patrol.

medical services are likely to cause medical harm. Yet, medical operations are prevalent and usually so popular with locals that they are overwhelmed with “patients.” The operations become medically meaningless in the process. They are attractive to locals because they are a novelty, and because locals incorrectly anticipate the receipt of a benefit. They are also opportunities to obtain free goods for sale in the black market according to one news article—

But . . . planners say the goodwill missions . . . also suffer from serious flaws. Among them . . . a lack of medicines and diagnostic tools that would help get patients long-term care; and locals’ tendencies to present false medical claims in order to get free medicines and goods . . . “Vitamins are huge. We may as well toss them out the door. As long as they walk out of here with something, they’re happy.” . . . That much was clear as Sadoon Karim, an Iraqi army medic, attended to patients during the mission in

Ur . . . A woman walked in and, in insistent Arabic, pointed to an array of medications on the table, demanding—and receiving—eight different kinds of pills, creams and ointments. . . After she left, Karim looked at his pillaged selection of drugs and shrugged. . . “It’s a hysteria disease here,” he said in English . . . In another room, . . . a healthy looking 23-year-old . . . complained of a variety of ailments. . . “A lot of times, little kids will come in and say, “We have arthritis,” . . . “They just want the pain medications. They don’t have any problems. They just want to see what we’ve got.” . . . Patients, for the most part, admit to that . . . “I don’t go to the government hospital,” Salah said, his hands full of free medications. “They don’t give me what I need.” . . . Another patient. . . who complained of diabetes, said he felt entitled to free medical care . . . “When we go to the hospital, we have to pay money,” he

said . . . Near the end of the mission, civil affairs Soldiers exasperatedly tried to stop women from carrying out entire boxes of clothing, food, and school supplies. The caretaker of the school in which the mission was held. . . complained that patients made off with school property . . . After the mission, members of the civil affairs unit gathered in their office at Forward Operating Base Loyalty and vented their frustration at the government's lack of participation, at patients' greediness and disorderliness, at the insufficiency of supplies and at the difficulty in winning trust in the course of a four-hour clinic . . . It was Captain Bill Billeter who pointed out the bright side . . . "I don't know how well we showed people that the government of Iraq cares about its people," he said. "But we showed we cared."¹⁸

This operation does not survive even a cursory course-of-action vetting process. The mission failed to improve civilian health in any significant way and probably harmed some people with inappropriate medications. The participants attempted to provide care for people with chronic illnesses, which is impossible. It created competition with the local hospitals, delegitimizing them. The woman with the deformed child certainly left disappointed: is it unreasonable to consider that such disillusionment may turn an uncommitted civilian toward the arms of insurgents? As reported, this operation's only redeeming quality was that it felt good to one of the participants, and pictures of it made nice slides in a command briefing.

A brief look at the numbers reveals the medical absurdity of the operation: 200 patients, four hours, one U.S. physician, one Iraqi medic, and several U.S. medics. At 50 patients per hour, the physician "evaluated" one patient every 1.2 minutes. Predictably, the operation rapidly degenerated into chaos, a free-for-all dispensing of unnecessary and potentially harmful medications, and even outright thievery.

If the commander's intent was (in part) to improve health, or to improve access to medical care in a Baghdad neighborhood, then what effective actions could his medical officer or planner have recommended? First, he should have counseled *against*

any attempts to provide diagnostic or curative medical services. Provision of preventive services, such as vaccination against childhood illnesses, educational programs regarding tobacco cessation, or hygienic and sanitation instruction directed at infectious disease prevention are medically sound and relatively benign. Identifying nearby open clinics and hospitals and marketing their hours and capabilities may be useful. Ensuring or providing safe passage of patients from their neighborhood to the clinics or hospitals and back may be helpful.

Note the Americans' frustration that the Iraqi government (Ministry of Health) would not participate in this Baghdad operation. One cannot really blame the Iraqis! Adding Iraqi physicians to a futile model of medical care does not improve it, and it may cause local physicians to think that American physicians are incompetents. It would be irrational for an Iraqi or Afghan physician to leave his relatively productive medical practice to spend six hours distributing vitamins and painkillers to a horde of people who may or may not have any medical problems and who he probably will never see again.

Medical operations are of dubious medical value, undermine efforts to build institutions, and explicitly violate medical rules of engagement, yet they are prevalent.¹⁹ This may be because they are relatively easy to execute, brief well to medically-naïve superiors, are emotionally gratifying for some restless doctors and medics, and generate positive press for self-consumption. Most likely, though, humanitarian medical operations are prevalent because commanders and their medical advisors incorrectly assume that BCT medical assets can effectively address indigenous medical problems.

While it is important for U.S. forces to engage the local population to create or maintain a deterrent presence and to develop cooperative relationships, doing so with a temporary sick call clinic is a mistake. Insecure civilians need a dedicated security presence in their communities. Providing security is a distinctive competency of a combat arms battalion commander and his Soldiers, whereas providing primary medical care to Iraqis or Afghans is not.

Using Medicine to Gain Influence

Most commanders probably do not engage in medical operations solely with humanitarian intent,

but rather use the operation as a vehicle with which to engage the local population, to gain influence (*wasta*), and otherwise to “win hearts and minds.” But we must acknowledge that using medical operations for these purposes is really nothing more than exchanging a commodity, *the illusion of medical care*, for cooperation or influence, because meaningful medical care is not usually provided. Unlike Hamas, which can successfully garner popular support by providing social services (including healthcare), U.S. forces in Iraq and Afghanistan, alien and without the intent or desire to remain indefinitely, cannot effectively do so.

The Ur operation described previously sought to generate goodwill in Baghdad by exchanging the illusion of healthcare for cooperation and cessation of violent behavior. This construct may be naïve. A committed religious fanatic or tribal or sectarian insurgent is not likely to change his behavior because an American doctor and Iraqi collaborator gave him a tube of ointment, or his mother a bottle of ibuprofen. An ambivalent civilian who receives a one-month supply of diabetes medication is not likely to flip to the government side as he feels the insurgent’s eye on him and continues to receive night-letters reminding him of the consequences to his family should he cooperate with the infidels. “Random acts of kindness,” if they are effective at all in modifying behavior (which is doubtful), are certainly not effective in the absence of security.

Counterinsurgents can purchase influence over ambivalent civilians with money. After all, we paid the Sons of Iraq with cash, not with medications.²⁰ The price of cooperation is relative to the level of risk the civilian is willing to accept for associating with Americans or the host-nation government. The higher the risk, the higher the price. Considering the medical and operational harms inherent to medical operations, would it perhaps be better to exchange a more benign commodity for influence? Anything of perceived value would likely do: cash, livestock, food, fuel, or potable water.

The Use of Medicine to Gather Intelligence

Commanders may conduct medical operations, in part to draw a crowd of permissive or friendly civilians from which to elicit tactically actionable information or to determine general attitudes, such

as opinions about the legitimate government, the perception of security, or feelings about coalition forces. In this situation, the illusion of medical care is bait. Considering the pitfalls of medical operations, using an alternative commodity to entice civilians would be preferable and equally as effective.

Using Medicine for Information Operations

When commanders use medical operations to generate positive content for information operations, they must overcome several obstacles. One is the mitigation of unintended consequences, both medical and tactical. The commander must determine how to conduct the operation without causing undue medical harm, without causing disappointment, without undermining the local health care system, and without otherwise countermanding counterinsurgency efforts.

Second, for the information operation to be effective, the commander must have the media present at the operation to project the message to the targeted local, national, or regional Islamic audience (e.g., *Al Jazeera*, *Iraq Daily*, *Kabul Weekly*, *Bakhtar News Agency*). *Stars and Stripes*, *Combat Camera*, and writers for Division or Corps news bulletins do not reach the target audience (unless we are performing for ourselves).

Conclusion and Recommendations

In general, battalion and BCT medical forces should not attempt to provide diagnostic and curative medical care to civilians, except in emergencies or in situations in which U.S. forces inadvertently caused the injury. Regardless of the commander’s motives, using the illusion of healthcare to engage the local population risks causing medical harm to those he intends to help, and perhaps more significantly, risks making tactical errors that are likely to undermine counterinsurgency strategy.

A commander can most effectively improve the health of civilians in his area of responsibility by treating the disease of insecurity rather than attempting to treat its symptoms. He can do so by improving real and perceived

safety, dispelling fears caused by insurgent propaganda, and increasing freedom of movement.

If a commander does employ his forces to provide medical care to civilians, the least medically harmful means is preventive medicine. If he does choose to use his medical personnel to attempt diagnostic and curative medicine, he should have feasible and acceptable (for the indigenous people) contingencies available to address those (the majority) who will present with chronic diseases or serious conditions.

Commanders and their medical advisors should not attempt to improve medical operations by adding indigenous physicians or medics to this unsustainable model of medical care. Doing so makes U.S. medical personnel appear incompetent in the eyes of our allies and draws valuable native medical resources away from productive use into a sinkhole of futility.

Commanders and their medical officers should avoid the temptation to divert tragic humanitarian cases into the U.S. evacuation system in an attempt to obtain temporary U.S.-standard medical care for them. Rather, when asked to intervene, they should

work with officials in the indigenous medical system to get the person the best available indigenous care, although the outcome may not be ideal from an American perspective.

What are some roles (other than providing combat health support) in which medical staff can be useful to their commanders? Medical officers can act as effective subject matter experts to their civil affairs colleagues who are responsible for the reconstruction of healthcare facilities and for planning public health campaigns. Medical officers and planners can benefit their local counterparts by offering training, establishing collegial relationships with them, and advising them on such issues as medical systems, staffing, and logistics. Medical officers should establish relationships with local clinic and hospital directors and facilitate meetings with their counterparts at the ministry level, with the aim of facilitating institutional development. Attending these meetings to help negotiate conflicts or find solutions to problems can be useful as a way to keep a finger on the pulse of the indigenous medical system. **MR**

NOTES

1. Counterinsurgency principles and imperatives are in Field Manual (FM) 3-24 (Washington DC: U.S. Government Printing Office [GPO], 15 December 2006).

2. Ibid.

3. Dana Hedgpeth and Sarah Cohen, "Money as a Weapon," *Washington Post*, 11 August 2008, A1, <www.washingtonpost.com/wp-dyn/content/article/2008/08/10/AR2008081002512.html?nav=emailpage> (18 December 2008).

4. Michael Gisick, "Iraqis come back to bombed-out village, seeking care, shelter," *Stars and Stripes Mideast Edition*, 31 January 2008, <www.stripes.com/article.asp?section=104&article=52067> (18 December 2008).

5. Anita Powell, "Medical clinics in Baghdad a hit with Iraqis," *Stars and Stripes Mideast Edition*, <www.stripes.com/article.asp?section=104&article=40663> (11 October 2006).

6. Louis Roug and Doug Smith, "War's Iraqi Death Toll Tops 50,000," *Los Angeles Times*, <articles.latimes.com/2006/jun/25/world/fg-deatholl25> (25 June 2006).

7. Federal Bureau of Investigation Uniform Crime Reports Database, 2007, database online, <www.fbi.gov/ucr/cius2007/data/table_08_mi.html> (18 December 2008).

8. Ross DeVol and Armen Bedrossian, "An Unhealthy America: The Economic Burden of Chronic Disease—Charting a New Course to Save Lives and Increase Productivity and Economic Growth," October 2007, Milken Institute Research Report.

9. United Nations High Commissioner for Refugees' Second Ipsos Survey on Iraqi Refugees, November 2007, retrieved from the U.N. Refugee Agency at <www.unhcr.org/cgi-bin/texis/vtx/home/opendoc.pdf?tbl=SUBSITES&id=476267512> (18 December 2008).

10. Powell.

11. C.R. Elspeth, and R.L. Mott, "Military Humanitarian Assistance: The Pitfalls and Promise of Good Intentions," In D.E. Lounsbury, ed., *Military Medical Ethics 2* (Washington, D.C.: Borden Institute, 2003), 805-30.

12. Rebecca Santana, "Botox in Bagdad? Iraqis go for a little nip, tuck," *Washington Times*, 21 March, 2010

13. Corps and division commanders typically formalize this prohibition in the medical rules of engagement.

14. Mike Pryor, "Paratroopers, Iraqi Police Provide Medical Aid in Sadr City," *American Forces Press Service*, 19 March 2007, <www.defenselink.mil/news/newsarticle.aspx?id=32512> (18 December 2008).

15. As General Petraeus wrote in 2006, "increasing the number of stakeholders [emphasis added] is critical to success." LTG David Petraeus, "Learning Counterinsurgency: Observations from Soldiering in Iraq," *Military Review* (January-February 2006): 2.

16. Michael Gisick, "Iraqis come back to bombed-out village, seeking care, shelter," *Stars and Stripes Mideast Edition*, 31 January 2008, <www.stripes.com/article.asp?section=104&article=52067> (18 December 2008).

17. For an illustrative example, see John Vandiver, "The medical rules of engagement: Army surgeon lobbies hard to save Iraqi girl's life with treatment at American hospital," *Stars and Stripes Mideast Edition*, 20 May 2008, <www.stripes.com/article.asp?section=104&article=54941> (18 December 2008).

18. Powell.

19. Petraeus.

20. Ad-hoc groups of Iraqi fighters, paid by the United States to provide local security. Wearing the Sons of Iraq off our payrolls may prove to be problematic, but a thorough discussion of that topic is beyond the scope of this paper.